Regional Planning in New York State for Hospitals and Mental Health

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INTERGOVERNMENTAL relations have been characterized in recent years by a heightened awareness of State governments of the need to overhaul and modernize administrative machinery. These governments realize that continued unwillingness or inability on their parts to meet the problems associated with secularization, industrialization, high concentration of persons in urban areas, and a generally expanding population can lead only to a further erosion of their powers and prerogatives by the Federal Government. Clearly the Federal Government will seek out new partners, such as the cities, or tackle the job alone if the States cannot handle these problems.

New York has been among the first States seeking to reassert its responsibility for meeting the needs of the State as an integrated entity. Progress has been made in regional planning and organization of services both for health and overall social and economic development.

A review of New York's efforts in planning for hospitals and mental health services illustrates the response of a State government for meeting the complicated contemporary problems and issues associated with the organization and delivery of health services.

Hospitals and Public Health Services

Regional planning and organization have been introduced for public health and mental health services. Perhaps the most important change involving public health services is the division of the State into a fixed number of planning regions and the strengthening and expansion of the State health department's role in formulating and administering overall health policy. To date these changes have been directed mainly at problems associated with hospitals and nursing homes. However the emerging organizational framework is believed, by such health policy leaders in the State as Marion B. Folsom, to be sufficiently elastic to eventually encompass general health services (*1*).

Though in existence for some time, regionalization in New York State was given firm legal basis in 1964 with the passage of the Metcalf-McCloskey bill, which gave formal recognition to seven hospital regional planning councils and prohibited establishment of any new ones (*2*). These councils were originally established in 1946 to assist in the administration of the Hill-Burton program. At the same time an advisory group, the State hospital review and planning council, was established to assist the health department draw up policy and coordinate activity concerning hospitals.

The Metcalf-McCloskey Act also expanded and altered the membership of the review and planning council to dilute the influence of any of the groups being regulated and assure a greater degree of public representation. Of the 31 persons on the council, no more than 15 can be representatives of hospitals and nursing homes or practicing physicians. To assure better coordination, each of the seven regional councils is allowed at least one seat on the State council (*3*).

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The State hospital review and planning council acts as a powerful buffer between the regional councils and the State health department. The Metcalf-McCloskey Act gave the State council power to establish and enforce standards for the organization and membership of the regional councils.

Membership standards developed by the State council are designed to guard against domination by hospitals and nursing homes at the regional level. Membership in the governing board of each regional council is limited to no fewer than 25 or more than 75 persons. Each council's governing board must be representative of the public and the geographic region served. No more than 49 percent of the membership can be physicians or persons in the full-time paid employment of hospitals or nursing homes. Each regional council is organized in the form of a nonprofit corporation with council members electing governing board members to 3-year terms. A member can serve no longer than 9 successive years.

The State council also requires that financing of the regional councils be sufficiently diverse to avoid domination by any single individual, group, or private interest. In fiscal year 1967, all but two of the seven regional councils received Federal support amounting to 50 percent of the approved areawide planning budget. For the same period, State appropriated funds provided $50,000 for each of the six upstate councils and $200,000 for the Planning Council of Southern New York, the council in the New York City metropolitan area. The ceiling on State aid to each region is 90 percent of nonfederally reimbursed expenditures. The regional councils obtain additional funds of varying amounts from philanthropy, industry, Blue Cross, and hospitals.

The powers of the State hospital review and planning council extend well beyond regulation of the regional councils. The Metcalf-McCloskey Act, together with the Folsom Act of 1965, gave the State council broad authority to formulate policy and standards. Subject to the health commissioner's approval, the State council has authority to establish and enforce standards for hospital certification, health department certification of schedules of rates, payments, reimbursements, grants, and other charges for hospital services, and uniform statewide reports and audits relating to the quality of hospital care, use, and costs.

Activities involving approval of hospital and related facility construction have been decentralized. Functional authority for construction and day-to-day services has been delegated to the seven regional councils because they are closer to the scene and members presumably are better informed than State officials. The regional council must initiate action and provide the first recommendation in a decision-making system involving the State hospital review and planning council and the health commissioner. All applications for construction go first to the health commissioner. The commissioner submits copies to the State council and to the regional council in the area of the proposed construction.

Although the commissioner has the final word, he is prohibited from overruling the recommendations of the State or regional council without first providing an opportunity for a public hearing. In addition, in all cases where operating certificates are revoked or permission for new bed construction is denied to hospitals or nursing homes, a public hearing can be requested by officials of the institution (*3*).

The potential for regional planning and organization in New York was increased considerably by the passage in 1965 of the Folsom bill, legislation vastly expanding the powers of the State health department in health facility construction, administration, and medical care (*4*). The legislation, which went into partial operation in February 1966, combines two approaches to strengthen and expand the health department's role—transfer of regulatory authority previously lodged elsewhere and creation of new regulatory authority.

Several functions formerly handled by the welfare department have been transferred to the health department, including responsibility for approval of all hospital and nursing home construction and receipt of data and reports used in processing construction applications. In the past, health department participation in the control of construction was limited to advising the department of welfare on the fitness of physical plant, equipment, and rules and bylaws to be used in the operation of a facility.

Also transferred from the welfare to the health department was the certification and inspection of hospitals and nursing homes. Previously, only New York and Pennsylvania relied on their welfare departments to supervise hospitals. The only significant function remaining in the department of welfare is the issuance of certificates of incorporation for new hospitals and nursing homes. Changing this would have required revising the State constitution (*3*).

Under the Folsom bill, the health commissioner has the responsibility to prescribe uniform statewide minimum standards for hospitals concerning cost analysis and reporting, utilization review, and quality of patient care. While assigning responsibility for these activities to the commissioner, the legislation places working authority for the formulation of policy and standards with the State hospital review and planning council (*4*).

The Folsom bill permits the health department to delegate powers of initial determination of cost, quality, and utilization control to the regional councils, although these powers are not spelled out in detail. Because of problems of staff shortages and unfamiliarity with local situations, the health department is expected to delegate as many of its newly acquired functions as possible to the regional councils (*1*). Given such delegation, regional councils should be able to do a better and more complete job of functional planning and play a larger part in total State planning for the organization, distribution, and delivery of hospital services. In this context, we can expect the regional councils eventually to incorporate responsibilities for planning well beyond hospital and nursing home services. The growing complexity of problems stemming from the rising public aspirations for ready access to comprehensive health care of high quality increases the pressure for orderly planning of health services in general.

The planning and supervisory responsibilities of the health department resulting from the Metcalf-McCloskey and Folsom legislation are a substantial expansion of the department's traditional concern with only environmental health and communicable disease control. A further expansion in the power of the State health department has developed in conjunction with Medicare and Medicaid.

The health department, by contract with the Social Security Administration, screens for certification approval for participation in Medicare all hospitals, mental hospitals, independent laboratories, and home health agencies seeking to participate in the program. In carrying out this function, the health department has three roles—consultation, certification, and liaison with other State programs. The department also is fiscal intermediary for all official home care agencies in the State and two voluntary home care agencies.

In the operation of the Medicaid program, all responsibility for administration and supervision of the medical care and health services have been transferred from the social welfare department to the health department.

The timing of these changes is convenient. The expansion and centralization of powers of the State health department and the prospects of a broader and stronger role for the seven regional hospital planning councils provide New York with some high-powered machinery for implementing the recently passed Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89–749). Many of the structural ingredients essential for putting together a viable system of coordinated, decentralized, comprehensive health planning appear to be present. Whether, in terms of commitment, the opportunity will be seized is, however, a matter of conjecture at this point. Also, in New York State as elsewhere in the nation, shortages of skilled professional manpower and of finances slow down program development.

Mental Health

Corresponding progress has been made in organizational revision and regional planning for mental health services (*5*). Since 1954, when the first State-local partnership program signaled the end of exclusive State responsibility for the care and treatment of the mentally ill and retarded, New York State has been revising its activities in the mental health field. More recently, based largely on a master plan prepared in 1962 by the department of mental hygiene, the agency responsible for administer-

ing the State mental health functions, a string of pace-setting changes have been introduced.

By no means completed, these changes include stepped-up support of community programs through removal of per capita ceilings for State aid to local governments, updated hospital admissions procedures and increased protection of patients' civil liberties, expanded support for research and personnel training and recruitment, and progressive new treatment methods and programs for special problem groups such as physically handicapped persons, mentally ill and retarded persons, emotionally disturbed children, alcoholics, and drug addicts. Other changes are decentralization of large, impersonal institutions into smaller, more therapeutically favorable units, intensive retreatment programs for formerly forgotten long-term patients, and rejection of a categorical treatment program and a custodial patient care orientation in favor of a coordinated, comprehensive, community-centered approach and an emphasis on active treatment.

In addition, the department of mental hygiene has been extensively reorganized. The number of operating divisions was reduced to make each division more manageable and representative of basic functional objectives, and the number of supportive staff positions was increased substantially.

Progress has also been made in regional planning and organization of services. This progress stems from the landmark State-local partnership act of 1954—the Community Mental Health Services Act—which brought local governments back into the provision of mental health services. In return for partial or total State support, depending upon the program, local governments are responsible for introducing and expanding community programs. In exercising this option, local governments must plan, administer, and coordinate comprehensive community mental health and mental retardation services.

To coordinate and rationalize burgeoning separate intergovernmental programs, the State was divided in 1960 into 10 mental health regions. In each region an advisory committee (consisting of members of community mental health boards from the region and directors of State institutions serving the region) was appointed to coordinate State and local efforts in the field of mental health.

In accordance with guidelines of a 1965 master plan, the mental health regions are now being revised. Prepared by a committee appointed by New York's Governor Nelson Rockefeller, who acted to take advantage of Federal grants recently made available to encourage State planning in mental health, the document reflects the growing awareness that prolonged institutionalization and removal of patients from normal currents of social interaction does more harm than good in most instances.

The principal thrust of the plan is to develop a system of care which would reduce length of hospital stay and allow patients to continue participation in the familiar flow of community and family life to the fullest extent possible. To implement this objective, the master plan calls for an expansion in the number of regional councils from 10 to 13, and a realignment of services and facilities in each region (State, local, voluntary, and private) to form a functionally balanced system for providing high-quality comprehensive care.

The objective is to move toward a system of community-based programs within a framework of administrative and economic requirements. The number of regions was expanded to give a stronger community flavor to those services necessarily encompassing a larger population and geographic area, such as intermediate and long-term care facilities.

The regions are combined into five super regions for the purpose of staffing facilities with expensive and scarce professional and technical planning personnel for overlapping programs and interests. Each super region is centered in a metropolitan area containing at least one primary medical center, including a medical school. Wherever possible, the super regions closely match those used by the health department for planning hospitals and related facilities. The 13 regions making up the five super regions encompass from two to eight counties, except New York City, which is singled out as a separate region because of its complexity.

Under the new plan, membership and functions of the regional advisory committees for mental health services are being enlarged. In addition to being representative of all agencies

and organizations involved in mental health services, the advisory committees now include consumer representatives. The primary function of regional advisory committees will be to direct and coordinate all elements in the area participating in mental health care.

Another aim is greater coordination and cooperation among mental health, public health, and other regional and local agencies sharing common or related interests. Toward this end, representatives from other planning agencies are being appointed to the advisory committees. This mechanism of overlapping membership operates unsystematically, however, and actual relationships are ad hoc. The experience generated to date is insufficient as a basis for firm conclusions, but the general feeling is that whatever cooperation takes place tends to be spasmodic, desultory, and largely unsatisfactory.

Three elements form the organizational core of each region—community mental health centers, community general short-term hospitals, and intermediate and long-term State mental hospitals.

In line with the goal of keeping patients within the therapeutic, supportive structure of community and family, the primary responsibility for coordination of the three types of treatment facilities is exercised at the local level by the community mental health center. Mental health centers are regarded as a concept rather than as a building or facility. In essence they are steering bodies, operated by either a community mental health board or department of mental health, charged with the responsibility for development and coordination of a program of mental care. The hope is that each program will provide treatment for persons of every age and type of psychiatric illness. Ideally, a program should be broad enough to meet the treatment requirements of the individual patient at each stage of his illness.

A variety of facilities and approaches may be used, for no single approach will meet all these demands. Each mental health center or complex is intended to serve a population of roughly 150,000 persons, although actual population may vary since some areas are rural and others urban. A total of about 150 centers throughout the State is planned.

Included in the range of services to be provided by each center are inpatient and outpatient care, part-time hospitalization (day, night, or weekend), emergency treatment, consultation service for community agencies, diagnostic and evaluative service, transitional and placement service (in halfway houses, vocational placements, foster homes, and nursing homes), rehabilitation (vocational, recreational, resocialization), after care, and formal community education programs.

Planners hope to upgrade the quality of mental health services, which have suffered from medical isolation in the past, by integrating them into general hospital services. It is hoped that by 1970 the gamut of services offered by mental health centers will be absorbed by affiliate community general hospitals. All community general hospitals are being urged to play a more active part in the provision of psychiatric services, either directly or through affiliation.

Inpatient care given in community mental health centers will be short term for the most part. Persons requiring further care after 30 days will be transferred to a State mental hospital.

The State mental hospital system is now being reorganized so that each hospital is to be limited to no more than 1,000 patients; a sufficient number of hospitals are to be built so that no hospital serves a population larger than 750,000 persons. The areas served by State hospitals are called catchment areas, and the population served by each hospital will comprise the population served by five community mental health centers. Each hospital will be related to and affiliated with the community mental health centers in its catchment area. Obsolete and inappropriately located facilities will be gradually phased out and abandoned. Most important, the idea of separate long-term care facilities for chronic patients is rejected. Throughout the State emphasis will be on early and active treatment and on keeping the patient as close as possible to community, friends, and family.

Interdepartmental Health Coordination

Until recently resolution of competing claims and coordination of related activities among departments was handled by the interdepart-

mental health and hospital council. Serving on it were heads of the departments of public health, mental health, social welfare, education, and insurance. While operating, the council had mixed success. In general terms, the council performed fairly well when it came to sharing information and working out joint approaches for noncontroversial matters. In cases of interdepartmental conflict and rivalry, however, it was less successful. It was fairly ineffectual in settling competing claims for policy and program responsibilities. Organized as a council of equals, there was no concentration or focal point of power sufficient to carry out decisions unfavorable to the agencies and interest involved.

On June 30, 1967, the council was dismantled and its functions were transferred to the health planning commission, a new agency with enlarged duties and powers. Unlike the council, which worked only with official State agencies, the commission is responsible for governmental and nongovernmental agencies alike, as well as for voluntary health organizations and private health institutions. Moreover, it has standard-setting and purse-string power to enforce its decisions. Housed in the Governor's executive office, the health planning commission was established by executive order on May 23, 1967 (*6*).

The primary mission of the health planning commission is to coordinate health planning throughout the State and formulate a comprehensive long-range health plan. In addition, the commission is set up to (*a*) supervise the administration of the State's planning activities under Public Law 89–749; (*b*) establish policies and procedures for the expenditure of public funds for comprehensive health planning of both public and private health services; (*c*) designate public or private nonprofit areawide health planning agencies in the State; (*d*) approve project grants to public or private nonprofit agencies or organizations for areawide health planning; and (*e*) review all plans of State agencies relating to the provision of health and mental health services to assure that such plans are in accordance with the comprehensive health plan.

The commission consists of nine members, many of whom served on the old interdepartmental health and hospital council. They are the health commissioner, the commissioner of mental hygiene, the commissioners of education, labor, local government, and social welfare, the superintendent of insurance, the chancellor of the State university, and the chairman of the narcotics addiction control commission. The health commissioner serves as chairman.

Advising the commission is a health planning advisory council consisting of representatives of governmental and nongovernmental health agencies and consumers of health services.

A major issue facing the new agency concerns the question of what to do with the five regional medical programs underway in New York City, Albany, Syracuse, Rochester, and Buffalo. Financed by the Federal Heart Disease, Cancer, and Stroke Amendments of 1965, the regional medical programs present a problem in public administration. Under the direction for the most part of powerful medical schools and organized to cut freely across conventional political boundaries, these programs are highly autonomous and fall outside the range of normal political and social controls. The action the health planning commission will take is conjectural at this point. However, it is perhaps significant that Governor Rockefeller appointed as the commission's executive director a man who had previously served in the State health department as a special consultant on heart disease, cancer, and stroke. The vigor and tone of the commission's future leadership might well depend on its handling of this issue.

General Social and Economic Development

Aware of the need for more informed and rational means of decision making to command a vigorous role in their relations with the Federal Government, New York State officials have carried regional planning beyond the confines of health services. About a year ago legislation was approved for the creation of a super planning agency, the office of planning coordination, to be part of the governor's executive office. The office, which began operating July 7, 1966 (*7*), was designed to consolidate regional development functions and federally assisted urban planning programs previously lodged in the office for regional development and the department of commerce, respectively, and to coordi-

nate the functional planning of executive agencies, such as departments of public health and mental hygiene. It is to relate such consolidation and coordination to the activities and development plans of municipalities, the Federal Government, and neighboring States in cases of shared interests and problems. Finally, in conjunction with these planning agencies, the office is to prepare development plans for the areas and regions of the State and a comprehensive development plan for the State as a whole.

In the health area, the office of planning coordination was boosted recently by the State's implementation of Public Law 89–749. In his executive order creating the health planning commission, Governor Rockefeller stipulated that the director of the office of planning coordination serve as a nonvoting, ex officio member of the commission. The Governor also has publicly stated his belief that "the comprehensive health plan will be a major input into the overall comprehensive State plan being developed by the office of planning coordination" (*6*).

The job of coordinating the functional planning of line agencies within the framework of an overall plan and meshing State plans with those of local and Federal governments was formerly handled by the office for regional development.

In 1964, 3 years after its founding, the office for regional development published a report entitled, "Change: Challenge: and Response," which continues to serve as the basic document for planning in New York State (*8*). Setting out a 60-year development plan for the State's cities, agricultural areas, and recreational and forest reserves, the report has been described as the most significant regional pronouncement since the founding of the Tennessee Valley Authority (*9*). The long-range development program it describes was begun in 1965 and comprises three major facets—regional plans, functional policies, and supporting services.

A commitment to regionalism forms the heart of the plan. For planning and development purposes, the State has been divided into 12 regions (*10*). General targets and policies in each region are determined by a regional council of community, business, and government leaders appointed by the Governor. The goal is to stimulate universal local planning. State and regional groups then draw and build upon the efforts of local planners. The function of the regional groups is to provide the localities with a wider common outlook and a framework for resolving problems cutting across local boundaries, such as those of traffic, water, sewage, and atmospheric pollution.

The functional policies of the 60-year plan will center on issues and problems requiring a statewide solution—social and economic development (health, public welfare, education, housing, public safety, civil rights, economic growth), urbanization, natural resources, transportation, and public facilities (colleges and hospitals).

Centralized programs to assist officials in planning and decision making are also being developed. They include forecasting population and economic trends, demographic descriptions and analyses, inventory and study of business activity, and cartographic services.

State governmental machinery has been further streamlined by the adoption of sophisticated new budgeting methods (*11*). Under the joint direction of the division of the budget and the office of planning coordination, State agencies are gradually shifting to a system called integrated planning-programing-budgeting, which in many respects is comparable to the system now being introduced in all Federal agencies. The aim is to relate systematically the expenditure of funds to the accomplishment of program objectives and social goals.

The hope is that in addition to assisting line departments to carry out program responsibilities, the system will spur and strengthen comprehensive statewide and regional planning. The power of the bureau of the budget to cut or add funds can be expected to serve as a powerful force toward this end. As a further aid to planning, Governor Rockefeller proposed in his 1967–68 budget message that the State establish a central data bank and a statewide telecommunications network (*12*).

The aim in New York State is to do long-range statewide and regional planning through the office of planning coordination, functional planning through the operating State departments and agencies, and up-to-date fiscal planning through the division of the budget (*13*).

The planning structure for the New York

State programs includes the following factors:

- local planning
- coordination of multiple local unit plans within a comprehensive regional context and planning on a regional basis for services transcending local control (such as water and sewage)
- State-level coordination of regional plans by executive line agencies (public health, transportation, education)
- coordination of line agency plans within the context of overall State needs by central bodies in the executive office of the Governor (such as an office of planning coordination or budget division)
- executive office allocation of State resources and program effort
- Federal financing and accompanying general guidelines for the shaping and pursuit of large-scale national objectives (such as improved health levels for the American people)

Summary

In an effort to bring government more closely in balance with the mounting complexities and requirements of contemporary society, New York State has undertaken in recent years to streamline its administrative-coordinative machinery and introduce regional planning for health and general developmental purposes. Although much remains to be done and the innovations are too new to be evaluated fully, sizable progress has been made.

Some changes in New York tie in with the emerging intergovernmental philosophy and with some of the new health planning legislation passed by Congress. They suggest a possible framework for coming to terms with the task of putting into practice the abstract partnership ideals of intergovernmental programs and the problems of comprehensive health planning. This framework is based on decentralized democratic planning at local and regional levels, statewide coordination of decentralized plans by executive agencies, and federally promulgated and supported policy guidelines to assist the States in defining their role in meeting national problems.

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